IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

No. 93-120

THOMAS JEFFERSON UNIVERSITY, d/b/a
THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether an administrative decision disallowing Medicare reimbursement to petitioner hospital for "otherwise reimbursable" categories of graduate medical education costs incurred on its behalf by a related medical school solely because petitioner did not claim Medicare reimbursement for those costs in prior years conflicts with the Medicare statute and regulations or is arbitrary and capricious.

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At issue is the validity of a 1990 administrative decision construing a 1966 regulation governing Medicare reimbursement for education costs. The agency's 1990 construction of the regulation is contrary to more than 20 years of consistent agency practice in the area of graduate medical education ("GME"). The agency's 1990 determination is invalid because (1) it is inconsistent with the plain wording and intent of the Medicare education regulation; (2) it contravenes the governing Medicare statute; and (3) it is arbitrary and capricious.

INTEREST OF AMICI CURIAE

The American Hospital Association ("AHA") is the primary national membership organization for hospitals in this country, consisting of approximately 5,400 hospitals and other health care institutions. The AHA's goal is to promote high-quality health care and health services for all through leadership and assistance to hospitals in meeting the health care needs of their communities. Many of the AHA's members are teaching hospitals.

The Association of American Medical Colleges ("AAMC") was founded more than a century ago to improve the process and quality of medical education. Its members include all accredited medical schools in both the United States and Canada; nearly 400 major teaching hospitals; more than 90 academic and professional societies representing some 72,000 members of medical facilities; and students and medical residents at these schools and hospitals. Strengthening the quality of GME is a matter of special concern to the AAMC and its many members.

The amici have a significant interest in this case because the challenged agency decision adversely affects the financial well-being of some of their teaching hospital members, thereby impairing the hospitals' ability to furnish high-quality GME. Of equal importance, however, is the amici's concern with the lack of fundamental fairness represented by the agency decision.

The regulation in question has never been controversial in the GME area in the past; the agency always construed the regulation consistently with its precatory phraseology. Suddenly, in 1990, the agency adopted a radical new construction, one which, had it been applied in 1967 (when the Medicare program began operations), would have precluded virtually any teaching hospital from ever receiving any Medicare reimbursement for GME, in clear contravention of Congressional intent. Moreover, the agency

did so without even expressly acknowledging the radical departure from prior policy, much less providing a rational explanation for the departure. The agency's current interpretation establishes absurd disparities among teaching hospitals based solely on the sophistication (or lack thereof) of the reimbursement claims filed in prior years. These disparities cannot be reconciled with the plain wording of the Medicare statute and regulations or with fundamental principles of fairness.

Principles of administrative law require, at a minimum, that an agency changing its course furnish advance notice, a rational explanation of what its new policy is, and a reasonable explanation for the change. The agency decision in this case fails on all scores. The decision below sets a very unfortunate precedent with ramifications for the amici's members (as well as for regulated parties in general) beyond the specific question addressed.

In recognition of the AAMC's and the AHA's interest in this case, both parties have consented to the filing of this brief.

STATEMENT

The petitioner's brief contains a full statement of the case. The amici rely on that statement. They recite here only facts which, in their view, are particularly worth noting.

I. GENERAL BACKGROUND

1. The Medicare statute was enacted in 1965 to furnish health insurance benefits for persons aged 65 or over. Pub. L. No. 89-97, § 102(a). Medicare providers were

reimbursed on the basis of their "reasonable cost." [1] 42 U.S.C. § 1395x(v)(1)(A).

2. The Secretary of what was then the Department of Health, Education, and Welfare and is now the Department of Health and Human Services ("the Secretary") issued implementing regulations in 1966. 31 Fed. Reg. 14,808. Then, as in 1985 (the cost year at issue), the Secretary's regulations provided for payment of Medicare's share of "the net cost of approved educational activities." 20 C.F.R. § 405.421(a) (1967). [2] "Net cost" was defined as "the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations." 20 C.F.R. § 405.421(b)(2) (1967). The Secretary's regulations also contained the same paragraph (c) (addressing, among other things, community support and the redistribution of educational costs) whose construction is at issue in this case. 20 C.F.R. § 405.421(c) (1967).

3. Since their original promulgation, the only significant changes to the education regulation relevant to this case have been to the definition of "net cost." In 1980, certain grants and donations were exempted from offset. 45 Fed. Reg. 51,783, 51,786-51,787. In 1984, the offset of grants and gifts was eliminated in its entirety. 49 Fed. Reg. 234, 296, 313. As a result, the only offset remaining in the regulations

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[1] In 1972, the statute was amended to provide for reimbursement of the lower of "reasonable costs" or "customary charges." See 42 U.S.C. § 1395f(b)(1). Only in unusual circumstances are a provider's customary charges less than its reasonable costs.

[2] The education regulation was originally codified at 20 C.F.R. § 405.421. In 1977, it was recodified as 42 C.F.R. § 405.421. 42 Fed. Reg. 52,826. In 1986, it was recodified as 42 C.F.R. § 413.85. 51 Fed. Reg. 34,790.

is for tuition. See 42 C.F.R. § 405.421(g) (1984); 42 C.F.R. § 413.85(g) (1993).

4. In 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for most inpatient operating costs, but retained cost reimbursement principles for certain costs, including medical education costs. Pub. L. No. 98-21, § 601(e); 42 U.S.C. § 1395ww(a)(4). In April 1986, Congress adopted a new payment methodology for GME costs for cost reporting years beginning on or after July 1, 1985. Pub. L. No. 99-272, § 9202. That system is not relevant to this case, which involves a cost reporting year subject to payment for GME costs under "reasonable cost" principles.

II. FACTS SPECIFIC TO CASE

1. Petitioner has been a Medicare provider of hospital services since the beginning of the program. It has trained interns and residents in GME programs for many years, but it did not begin to claim Medicare reimbursement for GME costs incurred by its related medical school for its GME program until 1974. From 1974 through 1983, petitioner claimed (and received) Medicare reimbursement for resident stipends and for the compensation and fringe benefits paid by the related medical school to faculty members for training petitioner's residents.

2. In 1984, petitioner expanded its Medicare GME claims to include the clerical and office space costs incurred by the related medical school for petitioner's GME program. The Medicare fiscal intermediary reimbursed petitioner's 1984 claims in full.

3. For its 1985 fiscal year (July 1, 1984-June 30, 1985), petitioner hired a national accounting firm to identify with particularity all of its allowable GME costs, including GME costs incurred on its behalf by the related medical school. The study demonstrated that, for many years, petitioner had

been underclaiming the amount of GME costs allowable under Medicare. For its 1985 fiscal year, petitioner sought reimbursement for GME costs in accordance with the results of the study. [3] The Medicare intermediary disallowed the increased costs claimed by petitioner, contending that reimbursement of those costs would violate paragraph (c) of the Medicare education regulation.

4. On November 17, 1989, the Provider Reimbursement Review Board ("PRRB or "Board") reversed the intermediary's disallowances. The Board concluded that reimbursement of petitioner's claims was consistent with paragraph (c) because:

> the Provider is merely claiming additional support costs for the GME programs it has historically operated utilizing the services of the related Medical School's faculty. The refinement of costs associated with these educational activities does not constitute a redistribution of costs from the educational unit to the patient care unit.

Petition Appendix ("Pet. App.") at 59a.

5. On January 18, 1990, the Administrator of the Health Care Financing Administration ("HCFA"), the agency within the Department of Health and Human Services responsible for administration of the Medicare program, modified the Board's decision. The Administrator stated:

> [T]hat the Provider did not claim these costs in an earlier cost year is evidence of the communities [sic] support for these activities. To allow the community

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[3] Petitioner's 1985 fiscal year was its last year subject to payment for GME under "reasonable cost" principles. From its 1986 fiscal year through the present, petitioner has been subject to payment for GME under the 1986 legislation establishing the GME per resident amount methodology.

> to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c).

Pet. App. at 35a. He held that petitioner "may only be paid for those medical education costs which it has traditionally claimed and been allowed prior to 1984." [4] Id. at 37a.

6. The HCFA Administrator did not rely entirely on paragraph (c) of the education regulation. He also held, in the alternative, that the additional categories of medical school education costs identified in the study "would not be allowable medical education costs under any circumstance." Id. at 36a. The Secretary abandoned this argument before the court of appeals. [5] In her brief filed in response to the petition for certiorari, the Secretary has conceded that, but for paragraph (c), the disputed costs are "otherwise reimbursable GME program costs." See Question Presented; see also Brief at 8.

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[4] The parties subsequently stipulated that petitioner was entitled to the increased GME costs identified in the 1985 study, including those incurred by the medical school, related to the categories of GME costs for which petitioner had received Medicare reimbursement prior to 1984. Pet. App. at 11a-12a n.5.

[5] The district court did not address the Administrator's holding on this point. However, in Ohio State University v. Sullivan, 777 F. Supp. 582, 588-590 (S.D. Ohio 1991), aff'd, 996 F.2d 122 (6th Cir. 1993), the court demonstrated the inconsistency of the Administrator's holding with Medicare principles. Following the Ohio State district court decision, the Secretary abandoned the HCFA Administrator's alternative holding in both the Ohio State litigation and the instant case. See Secretary's Petition for a Writ of Certiorari, Shalala v. Ohio State University, No. 93-696 at 6 n.5.

SUMMARY OF ARGUMENT

I. The Administrator's construction of paragraph (c) conflicts with its plain wording. Paragraph (c) is phrased in general, precatory, and explanatory language. It is properly read as providing the rationale for the specific provisions of the regulation. The Administrator has impermissibly converted the general language in paragraph (c) into independent prohibitions that conflict with the specific provisions. Moreover, his construction is contrary to binding agency policy issuances, as well as more than 20 years of prior agency practice. Consistent with its plain wording, the decisions in the Ohio State litigation, and the agency's prior practice, paragraph (c) applies only to a redistribution of educational costs which, unlike the costs of training interns and residents, are not "customarily or traditionally carried on by providers in conjunction with their operations," but rather are carried on by educational institutions.

II. The Administrator's construction conflicts with the Medicare statute. The statute expressly requires Medicare to bear its proportionate share of necessary costs. It does not exempt Medicare from this obligation if a provider waived its lawful entitlement in prior years.

The legislative history relied on by the Administrator clearly refutes his position. If the Administrator's construction of "community support" were correct, the ability of hospitals to operate GME programs prior to the enactment of Medicare would have precluded their ever receiving Medicare reimbursement. However, the legislative history shows that Congress believed communities were not supporting GME in 1965 and it was therefore necessary for Medicare to bear its share of these costs. There is no evidence that Congress ever reversed that judgment.

III. The Administrator's decision is arbitrary and capricious. It establishes irrational distinctions among similarly-situated hospitals based solely on the sophistication

of their prior Medicare claims. It makes no more sense for the Secretary to deny a provider's lawful current Medicare entitlement based upon a waiver in prior years than for the IRS to deny a tax deduction because a taxpayer failed to claim the deduction in prior years. Moreover, denying lawful claims because of waivers in prior years is just as absurd as reimbursing unallowable costs because of erroneous payments in prior years. Mistakes should be corrected, not perpetuated.

The Administrator's decision is simplistic and superficial. He eschewed all the "hard questions" raised by the case. He thereby failed to meet his obligation to provide a reasoned explanation for what was a dramatic change in course. Moreover, because the Administrator departed from his own legislative rules, he was required to act through rulemaking, not adjudication.

ARGUMENT

I. THE ADMINISTRATOR'S 1990 CONSTRUCTION CONFLICTS WITH THE PLAIN WORDING AND LONG-STANDING IMPLEMENTATION OF THE MEDICARE EDUCATION REGULATION.

A. Inconsistency of Administrator's Construction With Plain Wording of Regulation

The Administrator and the district court focused exclusively on paragraph (c) of the education regulation. Pet. App. at 14a, 33a. That was a mistake because, to be properly understood, paragraph (c) must be read in context.

As of 1983, the education regulation read in relevant part as follows:

> (a) A provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(b) *Definition--Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

....

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities,

revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(2) Effective for cost reporting periods beginning on or after January 1, 1978, grants and donations that the donor has designated for internship and residency programs in family medicine, general internal medicine, or general pediatrics are not deducted in calculating net costs.

42 C.F.R. § 405.421 (1983).

Prior to petitioner's 1985 fiscal year, Paragraph (g) was amended to read as follows:

Calculating net cost. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

42 C.F.R. § 405.421(g) (1984). Otherwise, the regulation remained unchanged.

In his 1990 decision, the Administrator construed paragraph (c) as precluding a hospital from receiving reimbursement for particular categories of education costs if it did not receive reimbursement for those categories in prior years. He stated that the absence of prior Medicare funding demonstrates "community support" and defined "community support" broadly to include "tuition, hospital fees, grants, [and] bequests." Pet. App. at 32a. The Administrator's

construction does not comport with the plain wording of paragraph (c), when read in context with the regulation as a whole, or with the Secretary's traditional understanding of that paragraph.

The governing rule is stated in paragraph (a): A Medicare provider is entitled to reimbursement of "its net cost of approved educational activities." Paragraph (g) defines with specificity the required deductions. Paragraph (b) defines "approved educational activities." Where requirements are imposed, mandatory language is employed. For instance, paragraph (b) states that the activities "must be licensed where required by State law" and, where not so required, "must receive" alternative specified approval. (Emphasis added.)

The wording of paragraph (c) contrasts sharply with the specificity and mandatory phraseology of other provisions in the regulation. It is phrased almost entirely in descriptive or precatory language. It includes only one flat declaratory statement: "[I]t is necessary that support be provided [for approved educational activities] by those purchasing health care." The language in paragraph (c) is naturally read as explaining the rationale for the specific provisions in the regulation.

The Administrator did not adopt the natural reading. Instead, in his 1990 decision, he converted the general, explanatory language in paragraph (c) into all-encompassing, independent prohibitions which are fundamentally at odds with the liberalization of the definition of "net cost" that occurred during the 1980s. Originally, the regulation required the offset of "any reimbursements from grants, tuition, and specific donations." 31 Fed. Reg. 14,808, 14,814 (1966); 20 C.F.R. § 405.421(b)(2) (1967). In 1980, the regulation was amended (effective for cost reporting years beginning on or after January 1, 1978) to preclude the offset of "grants and donations that the donor has designated for internship and residency programs in family medicine,

general internal medicine, or general pediatrics." 45 Fed. Reg. 51,783, 51,786-51,787 (1980); 42 C.F.R. § 405.421(g) (1980). On January 3, 1984, it was further amended to preclude the offset of any grants or donations. 49 Fed. Reg. 234, 296, 313 (1984). The regulation in effect during petitioner's 1985 fiscal year required only the offset of "revenues . . . from tuition." 42 C.F.R. § 405.421(g) (1984).

The Administrator's decision renders paragraph (g) meaningless. His construction of paragraph (c) requires the offset of all the revenues specifically exempted by the amendment of paragraph (g) during the early 1980s. Moreover, his suggestion that "hospital fees" (i.e., patient care revenues) should be considered "community support" conflicts not only with paragraph (g) but also with the statement in paragraph (c) that, because of the absence of community support, "it is necessary that support be provided by those purchasing health care," thus obviously excluding "patient care revenues" from "community support." In one fell swoop, the Administrator has attempted, through adjudication, to reverse what his regulations clearly prescribe.

Paragraph (g) governs Medicare offsets for Medicare education costs. Any construction of the general language in paragraph (c) must be consistent with paragraph (g). The Administrator's construction fails because it conflicts with the clear mandate of that paragraph.

Significantly, the Secretary's extensive cost reporting forms and instructions during the cost reporting years at issue also contradict the Administrator's 1990 construction of the regulations.[6] The 1983 cost reporting form and

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[6] Medicare providers report their annual claims in a lengthy document known as a Medicare cost report. See 42 C.F.R. §§ 413.20(b), 413.24(f) (1992). The Secretary has issued very

(continued...)

accompanying instructions specifically require the offset of grants and donations and nursing school tuition, as mandated by the Secretary's definition of "net cost" prior to the 1984 amendment to the Medicare education regulation. See 1983 Instructions, ¶ 1216; see also Form HCFA-2552-83, Worksheet A-8, line 27. The 1984 cost reporting form only requires an offset of nursing school tuition, consistent with the amended definition of "net cost." See Form HCFA-2552-84, Worksheet A-8, reprinted in Medicare & Medicaid Guide (CCH), Report No. 457, 2d Extra Ed., Part II (Apr. 30, 1985). Nothing in the Secretary's 1983 or 1984 cost reporting forms or instructions suggests the necessity of further deductions based on paragraph (c) of the Medicare education regulation.

B. Correct Construction of Paragraph (c)

The very general, precatory language in paragraph (c) does not establish prohibitions which would alter the principle in paragraph (a) that a provider is entitled to reimbursement of "its net cost of approved educational activities" or the specific provisions in paragraph (g) defining the costs included and the revenues offset in calculating net cost. In-

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[6](...continued)
detailed instructions for the completion of cost reporting worksheets. See, e.g., Provider Reimbursement Manual ("PRM"), Part II, Ch. 15 - Provider Cost Reporting Forms and Instructions, Form HCFA-2552-84, reprinted in Medicare & Medicaid Guide (CCH), Report No. 457, 2d Extra Ed., Part I (April 30, 1985) (instructions for the cost reporting form prescribed for cost reporting periods beginning after September 30, 1983 and before October 1, 1984) [hereinafter "1984 Instructions"]; PRM, Part II, Ch. 12 - Provider Cost Reporting Forms and Instructions, Form HCFA-2552-83 (instructions for the cost reporting form prescribed for cost reporting periods beginning after September 30, 1982 and before October 1, 1983) [hereinafter "1983 Instructions"].

stead, paragraph (c) is properly read as providing the rationale for reimbursing education costs and the philosophical underpinning for the specific provisions in the regulation. For instance, to the extent that the words in paragraph (c) regarding community support have current relevance, [7] they explain why certain revenues should be deducted from gross education costs to calculate the "net cost" reimbursable under Medicare. Paragraph (g), in turn, specifies exactly which revenues must be offset.

The reference to "redistribution of costs" in the final sentence of paragraph (c) must be understood in light of the fact that educational activities under Medicare include not only the training of interns and residents, but also the training of nurses, medical students, and paramedical specialists. [8] The training of residents is entirely clinical; the residents have already successfully completed years of classroom training for which they have received an M.D. degree. Pet. App. at 16a-17a. In contrast, the education of nurses, medical students, and paramedical specialists involves partly clinical training and partly classroom instruction. Traditionally, classroom instruction for those students has often taken place in educational institutions. It is understandable that Medicare would not wish to begin reimbursing providers for the classroom instruction traditionally provided in educational institutions, not providers.

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[7] The references track language from a 1965 Senate report discussed in § II.B below. They may simply reflect the Secretary's and Congress' hope in 1965 (a hope as yet unfulfilled) that local communities would eventually undertake responsibility for medical education.

[8] Paramedical specialists include, among others, inhalation therapists, physical therapists, occupational therapists, and X-ray technicians. 42 C.F.R. § 413.85(e).

It is a mistake to read the words regarding "redistribution" in isolation. They are part of a sentence that begins: "the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations." Those words limit the scope of the "redistribution" language which follows. Accordingly, when read in context, the sentence as a whole precludes only a redistribution of costs for educational activities which, unlike the training of interns and residents, are not "customarily or traditionally carried on by providers in conjunction with their operations," but rather are carried on by educational institutions. That was the unanimous conclusion of the PRRB. Pet. App. at 59a. That was also the conclusion of the district court and the Sixth Circuit in the Ohio State litigation involving this issue. 777 F. Supp. at 585-587; 996 F.2d at 124.

The distinction drawn by the Ohio State courts between clinical training and classroom instruction in non-provider settings finds specific support in section 404.2 of the Provider Reimbursement Manual ("PRM"), an interpretative guide issued by the Secretary. Joint Appendix ("J.A.") at 56-58. That section (addressing specifically the costs of approved nursing and paramedical education programs) provides that the costs incurred in provider-operated programs "including costs of classroom training and costs of clinical training are allowable." PRM § 404.2A; J.A. at 56. For non-provider-operated programs supported by providers, it notes that the "clinical training portion generally is conducted in a provider or other health care setting" and states that the "[c]osts incurred for the clinical training at the provider are allowable." PRM § 404.2B; J.A. at 56. However, with respect to the costs "which are related to the classroom portion" in such non-provider-operated programs, the Manual provides for reimbursement only if, among other things, there is not "a redistribution of non-provider costs to the provider." PRM § 404.2B.1; J.A. at 57. Thus, the Administrator's application of paragraph (c) to the costs of

clinical training is inconsistent with the Secretary's own interpretative guide. [9]

Further support for the Ohio State interpretation of paragraph (c) is found in Intermediary Letter No. 78-7, a policy guide issued by the Secretary in February 1978 addressing reimbursement to teaching hospitals of costs incurred on their behalf by related medical schools. The letter states that such costs are allowable provided that they "would be allowable if incurred directly by the hospital rather than under such arrangement." Pet. App. at 64a. The letter provides detailed instructions and worksheets for identifying and documenting the related costs. Id. at 64a-66a. [10] Nowhere does it suggest that the redistribution language in paragraph (c) might be a barrier to a teaching hospital claiming education costs incurred on its behalf by the related medical school. [11]

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[9] In his decision, the HCFA Administrator relied on PRM § 406, which provides that "[t]he traditional practice followed in the past with respect to types of services rendered and the costs related thereto between providers and educational institutions shall be followed." Pet. App. at 33a. That provision is of no assistance to the agency in this case. The "traditional practice" (as recognized in PRM § 404.2) is that clinical training is the responsibility of providers, not educational institutions; the education of residents consists entirely of clinical training and is conducted entirely in patient care settings.

[10] The worksheets have been omitted from the Petition Appendix, but may be found at [1978 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 28,895.

[11] Paragraph (c) was part of the original Medicare education regulations published in 1966, and thus preceded the issuance of Intermediary Letter 78-7 by nearly twelve years.

Had the construction adopted in the Administrator's 1990 decision represented the Secretary's view in 1978, the contents of Intermediary Letter 78-7 would have been dramatically different. Any instructions to the intermediary on the subject of related medical school costs would have begun with the admonition that a hospital could not claim the education costs incurred by a related medical school unless it had done so in prior years. Moreover, even teaching hospitals which had done so in prior years would have been barred from identifying new categories of GME costs not previously claimed. Such language is conspicuously absent from Intermediary Letter 78-7.

Finally, additional support for the Ohio State holding is found in the preamble to the 1989 GME reaudit regulations. [12] The Secretary addressed therein whether a hospital's claims for GME costs incurred on its behalf by a related medical school might constitute a "redistribution of GME costs." 54 Fed. Reg. 40,302 (1989). The Secretary concluded that "services that are both related to the care and treatment of the hospital's patients and furnished in support of the training of interns and residents meet the requirements for payment." Id. She also concluded that the liberalization of the Medicare definition of "net cost" would preclude the offset of any grants or donations. Id. Nothing in the

[12] On September 29, 1989, the Secretary issued final regulations to implement the new payment methodology for GME costs. 54 Fed. Reg. 40,286. Under that methodology, hospitals are paid for future years based on their GME "reasonable costs" per intern and resident for a base year, updated for inflation. 42 U.S.C. § 1395ww(h). The Secretary's regulations required a reaudit of GME costs incurred during the base year. The accompanying preamble stated that "no new reimbursement principles will be applied during the reaudit" and described the agency's intent as "to ensure that the reimbursement principles in effect during the GME base period were correctly applied." 54 Fed. Reg. 40,301 (1989).

Secretary's rather detailed statement suggests that paragraph (c) establishes any independent barrier to reimbursement, even though the Secretary was expressly addressing whether claiming medical school costs as GME costs would constitute "a redistribution of GME costs." Id.

C. Inconsistency with Agency Interpretations and Practice

The Administrator's 1990 construction marks a radical departure from more than 20 years of consistent agency practice. That is evident from PRM § 404.2, Intermediary Letter No. 78-7, the liberalization of the definition of "net cost" that occurred during the early 1980s, the Secretary's cost reporting forms and instructions, and the preamble to the 1989 regulations governing reaudits of GME base years--all discussed in the preceding subsections. Further evidence is furnished by correspondence in the administrative record addressed in petitioner's brief.

Prior to the enactment of the Medicare program, hospitals obviously operated their GME programs without Medicare funds. Under the HCFA Administrator's 1990 construction, that fact should have precluded hospitals from receiving Medicare reimbursement for any GME programs in existence prior to Medicare. That is not, however, what happened. From the beginning of Medicare, hospitals with GME programs routinely sought reimbursement for Medicare's share of the net cost of the programs, and Medicare routinely paid the hospitals' claims.

The history of Medicare reimbursement for petitioner's GME costs is also noteworthy. In his decision, the Administrator noted that petitioner had operated its GME program for many years before claiming, for the first time in 1974, Medicare reimbursement for GME costs incurred by its related medical school. Pet. App. at 32a. Under the Administrator's current interpretation, since petitioner had not received Medicare reimbursement for those costs in prior

years, it would have been precluded from receiving Medicare reimbursement not only for 1974 but forever. That, of course, is not what happened. Consistent with the plain meaning of the education regulation, Medicare immediately began reimbursing petitioner's claims in 1974 and has continued to do so.

The change that occurred in petitioner's GME reimbursement claims in 1974 was far more dramatic than that which occurred in 1985. In 1974, petitioner began claiming GME costs never claimed before. In 1985, petitioner simply refined the methodology for establishing the amount of those costs. The 1974 claims were not considered a violation of paragraph (c) in 1974. That the Administrator's 1990 decision found the far more modest 1985 change to be a violation illustrates how radically the agency's current construction departs from traditional Medicare practice.

Likewise, the commentary published by the Secretary in the preamble to the 1989 regulations governing reaudits of the GME base year contradicts the Administrator's 1990 decision. The Secretary addressed therein whether, on reaudit, "hospitals should be able to introduce additional GME costs not previously claimed . . . to augment base-period GME costs." 54 Fed. Reg. 40,301 (1989). The Secretary responded that such costs could be allowed if the provider was able to provide documentation from the GME base year supporting the legitimacy of the costs. Id. Under the Administrator's 1990 construction, of course, that would not be the correct answer. If the GME costs "were not previously claimed," paragraph (c) would, under the Administrator's view, preclude Medicare reimbursement from ever being claimed for those costs. That was not, however, the Secretary's answer in September 1989 -- less than four months before the Administrator's decision in this case.

D. Necessity of Rulemaking

This is not a case in which the Administrator has sought to reverse through adjudication a policy adopted through adjudication. Here, the Administrator has sought to retroactively reverse through adjudication policies established by the Secretary's regulations and published interpretative guides.

An agency is, of course, bound by its own rules. United States v. Nixon, 418 U.S. 683, 694-96 (1974). If it wishes to reverse those rules, it must proceed by notice and comment rulemaking, not adjudication. American Federation of Government Employees v. Federal Labor Relations Authority, 777 F.2d 751, 758-760 (D.C. Cir. 1985). Moreover, any such reversal may apply only on a prospective basis. [13] Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988). Accordingly, even if the policy adopted in the Administrator's decision were consistent with the Medicare statute (addressed in § II below) and the Administrator had furnished a reasoned explanation for changing course (addressed in § III below), the Administrator's decision would nonetheless be invalid because the Administrator has attempted to apply his new policy without employing the mandatory notice and comment procedures of the Administrative Procedure Act.

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[13] In 1992, the agency issued a proposed rule designed to adopt the Administrator's new construction. See 57 Fed. 43,659, 43,672 (proposed 42 C.F.R. § 413.85(c)(2)). The rule has not yet been finalized.

II. THE ADMINISTRATOR'S 1990 CONSTRUCTION VIOLATES THE MEDICARE STATUTE.

A. Statutory Language

The Administrator's 1990 construction results in great disparities among similarly-situated hospitals. Suppose, for instance, that in Year X, Teaching Hospitals A, B, and C all had related medical schools which incurred $1 million in costs in connection with the administration of the Hospitals' GME programs. For prior years, Hospital A had accurately identified and claimed all medical school costs related to GME; Hospital B had identified and claimed only 50% of the medical school costs; and Hospital C had claimed none of the medical school costs. Under the Administrator's view, past practice would be binding. Hospital A's allowable costs in Year X would be $1 million; Hospital B's, only $500,000; and Hospital C's, nothing. Thus, even though Hospital C's Medicare patients received the same benefit from the training of interns and residents in Year X as Hospital A's, Hospital C would have to suffer in Year X and for all other years because in prior years it had waived its Medicare entitlement. The Administrator's construction creates enormous competitive disadvantages among hospitals that are providing the same degree of benefit to the Medicare patients they serve. It also perpetuates forever windfalls that the government has received because of hospital waivers in prior years.

There is no basis in the Medicare statute for the creation of such irrational disparities. The Medicare statute defines "reasonable costs" as "the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A). That Hospital C failed to claim Medicare reimbursement for a particular cost in prior years does not render the cost "unnecessary in the efficient delivery of needed health services." If the cost is necessary

in Hospital A's "efficient delivery of needed health services," logically it must also be "necessary" in Hospital C's — whether or not Hospital C waived its Medicare claim in prior years.

The cardinal principle of Medicare "reasonable cost" reimbursement is that Medicare must pay its fair share of health care costs. Specifically, the statute requires the Secretary's reimbursement principles to take into account both direct and indirect costs so that "the necessary costs of efficiently delivering covered services to [Medicare patients] will not be borne by [non-Medicare patients], and the costs with respect to [non-Medicare patients] will not be borne by [Medicare]." 42 U.S.C. § 1395x(v)(1)(A)(i). This provision is often known as the proscription against cross-subsidization.

There is no question that the costs in dispute in this case are "necessary." The Secretary has conceded that, but for petitioner's failure to claim them in the past, the disallowed costs are "otherwise reimbursable GME program costs." See Secretary's Petition Brief, "Question Presented." In the case of Hospital A (in the hypothetical above), the costs will be reimbursed. But the proscription against cross-subsidization would not allow a distinction between Hospitals A and C. The statute does not permit the Secretary to shift Medicare costs to non-Medicare patients if a hospital voluntarily permitted such a shift in past years by failing to claim Medicare's share. Rather, it places an affirmative duty on the Secretary to ensure that Medicare pays its fair share of "the necessary costs of efficiently delivering covered services."

Numerous courts have struck down the Secretary's administrative decisions relating to education costs based on the proscription against cross-subsidization. See, e.g., Ohio State University v. Sullivan, 777 F. Supp. at 587; Loyola University of Chicago v. Bowen, 905 F.2d 1061, 1073 (7th Cir. 1990); University of Cincinnati v. Bowen, 875 F.2d

1207, 1212 (6th Cir. 1989). The Administrator's 1990 decision is equally violative of this proscription.

B. Legislative History

In his decision, the HCFA Administrator relied on a passage from the Senate Report accompanying enactment of the Medicare statute. Pet. App. at 33a. The passage states:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

S. Rep. No. 404, 89th Cong., 1st Sess. 36, reprinted in [1965] U.S.C.C.A.N. 1977 (1965).

That passage, far from supporting the Administrator's decision, refutes it. The Administrator essentially held that the absence of Medicare funding in past years demonstrates "community support" which precludes Medicare funding for current or future years. Under that logic, hospitals entering the Medicare program in 1967 would not have been entitled to Medicare reimbursement for educational costs because their ability to operate the programs in the past without Medicare funding evidenced "community support."

But that was clearly not the congressional committee's view of "community support." The cited passage reflects the committee's belief that in 1965 communities were not providing the necessary support, and it was therefore

necessary for Medicare to bear its fair share. It is obvious, therefore, that the committee, unlike the Administrator, did not equate the absence of Medicare funding in the past with "community support." Moreover, there has been no general undertaking by communities in the past 29 years to support hospital educational activities which would render unnecessary the Medicare support which Congress stated was necessary when Medicare was enacted. Thus, the Administrator's decision is inconsistent not only with the plain wording of the Medicare statute (which he ignored), but even with the legislative history upon which he relied.

III. THE ADMINISTRATOR'S 1990 DECISION IS ARBITRARY AND CAPRICIOUS.

Under the arbitrary and capricious standard, an agency must consider all relevant factors and "articulate a satisfactory explanation for its action including a "rational connection between the facts found and the choice made.'" Motor Vehicle Manufacturers Association of the United States, Inc. v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983), quoting, Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168 (1962). Moreover, "an agency changing its course . . . is obligated to supply a reasoned analysis for the change. . . ." Motor Vehicle, 463 U.S. at 42.

The result reached by the HCFA Administrator is inherently implausible. Denying what the Secretary has conceded were "otherwise reimbursable GME program costs" because petitioner waived its entitlement to reimbursement for those costs in prior years is not only inconsistent with the Medicare statute, but it makes no sense. The IRS obviously could not deny a deduction for interest on a home mortgage because a taxpayer failed to claim the deduction in prior years. Nor could a welfare agency deny welfare benefits to an otherwise qualified applicant because he could have qualified, but failed to apply, for welfare in

prior years. The distinction drawn by the Administrator is equally ludicrous.

The logical ramifications of the Administrator's position should also be considered. If past practice is the criterion, it logically follows that a hospital which has mistakenly received GME reimbursement for unallowable costs in the past should continue to be reimbursed for those costs. The Secretary would undoubtedly object to making such payments, and she would, of course, be right. But it makes no more sense to deny allowable costs because a hospital waived its lawful entitlement in prior years than to reimburse unallowable costs because a hospital was mistakenly reimbursed in prior years. Mistakes should be corrected, not perpetuated.

Since the Administrator did not even admit that he was changing agency policy, he obviously could not provide a reasoned explanation for the change. [14] And, in fact, the Administrator's decision is remarkably simplistic, superficial, and conclusory. As the following demonstrates, the Administrator avoided all the "hard questions" relevant to a rational consideration of the propriety of changing a policy in effect for the prior 23-year history of the Medicare program.

1. The threshold question, of course, should be whether the change is consistent with the Medicare statute. As discussed in § II above, the Medicare statute bars the Secretary from shifting Medicare costs to other payors. Just a few months before issuance of the Administrator decision

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[14] An agency may not change its legislative rules through adjudication. American Federation of Government Employees, 777 F.2d at 758-760. Thus, even if the Administrator had furnished a reasoned explanation for the change, his action would nonetheless have been contrary to law because he did not utilize rulemaking procedures. See § I.D. above.

in this case, another Administrator decision involving education costs was reversed for violating this cardinal principle of Medicare reimbursement. See University of Cincinnati v. Bowen, 875 F.2d at 1212. Yet the Administrator failed even to consider the consistency of his new construction with the Medicare statute.

2. As discussed above, the Administrator's construction creates great disparities among similarly-situated hospitals. Yet the Secretary failed even to consider whether it is rational to create such disparities or equitable to penalize hospitals for prior waivers of reimbursement.

3. The Administrator failed to explain why the 1985 refinement of petitioner's GME claims constituted a violation of paragraph (c) when the filing of the original claims in 1974 did not.

4. The Administrator cited paragraph (c) of the education regulation as though the language ipso facto supported his result. But the Administrator never actually analyzed the language of the regulation. He did not consider, for instance, the relevance of paragraphs (a), (b), and (g). He did not note that paragraph (c), unlike other paragraphs in the regulation, is phrased in general, explanatory, and precatory language. He did not address why such language should suddenly be construed as independent "prohibitions" when it had not been so viewed in the past. He chose to ignore the liberalization of the definition of "net cost" that had occurred during the early 1980s. He made no attempt to reconcile his view of the general language in paragraph (c) with the specific language in paragraph (g) regarding offsets. He simply quoted paragraph (c) and declared magisterially that the paragraph obviously meant what, in fact, the Secretary had never before read it to mean.

5. Similarly, the Administrator simply cited the passage from the 1965 Senate report discussed in § II.B above, as though it were obvious that the language supported his

position. In fact, it is not at all obvious. The Administrator did not attempt to reconcile his broad view of "community support" with the Senate committee's belief that communities were not supporting hospital educational activities in 1965 and that it was therefore necessary for Medicare to bear its fair share. He also did not address whether there is any evidence that Congress had reversed its 1965 judgments regarding the inadequacy of community support and the necessity of Medicare funding. He also did not attempt to identify any growth in "community support" that had occurred since 1965 that would justify a departure from the Secretary's traditional position or Congress' mandate.

6. The Administrator did not address whether his new construction was consistent with the agency's published interpretations. He ignored, among other things, Intermediary Letter 78-7, PRM § 404.2, the Medicare cost reporting worksheets and instructions, relevant correspondence in the administrative record, and statements from the preamble to the 1989 GME per resident amount regulations applicable to this issue -- all discussed in § I above. He thereby avoided the hard task of explaining why he was not bound by the agency's prior interpretations, as reflected in those documents.

7. The Administrator did not address whether there was any change in circumstances which would justify a departure from the agency's prior policy. The only factor cited as a change was, in fact, not a change at all. The Administrator intimated that "the implementation of PPS and the corresponding provision for pass-through medical education costs" provided incentives for hospitals to claim costs not previously claimed. Pet. App. at 34a. That is clearly not true. PPS changed the reimbursement methodology for inpatient operating costs. It had no effect on reimbursement for medical education costs. See 42 U.S.C. § 1395ww(a)(4). For the year at issue, those costs continued to be reimbursed on a "reasonable cost" basis, as they had

since 1965. Accordingly, the incentive to identify GME costs accurately was created not by the enactment of PPS in 1983, but by the enactment of the Medicare statute in 1965.

Hospital efforts to identify GME costs more accurately were not new. Indeed, the reason that the Secretary issued Intermediary Letter 78-7 in February 1978 was to furnish hospitals and intermediaries with guidance regarding the identification of GME costs incurred by related medical schools. Moreover, there was nothing wrong with a provider asking Medicare to bear its fair share of all allowable costs; that is, after all, specifically what the Medicare statute commanded the Secretary to do. 42 U.S.C. § 1395x(v)(1)(A)(i).

8. The Administrator failed to accurately assess the evidence in the case. For instance, his statement that the Board's decision would allow "all costs for pre-existing activities . . . [to] be shifted, carte blanche, to the provider from the teaching institution" is absurd. Pet. App. at 34a-35a. The provider was claiming only medical school costs incurred in support of its GME program, which was only a small percentage of total medical school costs. Moreover, Medicare does not reimburse all allowable costs; it reimburses only its share based on the proportion of Medicare patients to total patients.

The foregoing analysis demonstrates that the Administrator ignored many relevant factors and failed to provide any explanation (much less a rational one) for departing from the agency's established policy. Accordingly, the Administrator's decision is clearly arbitrary and capricious.

CONCLUSION

For the foregoing reasons and the reasons stated in Petitioner's Brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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